GRAND RAPIDS HOME FOR VETERANS
3000 Monroe Avenue, NW
Grand Rapids, Michigan 49505
Phone (616) 364-5300
Toll Free: 1-800-MICH-VET

MICHIGAN DEPT OF MILITARY AND VETERANS AFFAIRS

GRAND RAPIDS HOME FOR VETERANS

APPLICATION FOR ADMISSION

Thank you for your interest in the Grand Rapids Home for Veterans. ***Your application will be given immediate attention.***
You can help the application process by submitting the following documents or information with your application.

■ MEDICAL

Medical history and physical exam of the applicant within the past 90 days. *(Required for admission.)*

Chest x-ray report of applicant within the past 30 days. *(Required for admission.)*

■ DOCUMENTS

DD-214 (Report of Separation, Military Record of Service, or Enlistment Record.)

Birth certificates for all minor children being claimed as dependents.

Marriage certificate if currently married.

Divorce papers or death certificate for all prior marriages of either the veteran or spouse if currently married.

Widow(er) needs to submit marriage certificate and veteran's death certificate.

If applicable: Guardianship paper, Conservatorship paper, Power of Attorney, Durable Power of Attorney, Patient Advocate form.

■ INSURANCE INFORMATION

Copies of insurance cards, including Medicare and secondary insurance if applicable.

Copy of nursing care insurance policy if applicable.

■ FINANCIAL

Verification of income and assets. This includes copies of any current bank account statements, land contracts, Social Security or other pension award letters or checks.

■ TAXES

If married, a copy of the past year's federal income tax forms.

■ FUNERAL ARRANGEMENT

Copies of any prepaid funeral arrangement papers.

■ CONTACT PERSON

Name of contact person for medical information if applicant is currently in another health care facility.

■ WHEELCHAIR RENTAL

If renting a wheelchair, check with rental company to see if the insurance company will continue to cover the wheelchair after admission to a veterans' facility. (GRHV can provide a wheelchair after admission.)

After the application is received, it is reviewed for completeness, eligibility, and level of care. The applicant (or interested other party) will receive a call from the Admissions Office to schedule an admission date and time, indicate placement on the waiting list, or advise you if we are unable to meet the needs required.

Thank you for your cooperation. If you have any questions or wish to know the status of your application, please call (616)364-5389 locally or 1-800-642-4838.

At the time of admission, you will be asked to sign a Member Contract. The purpose of this contract is to outline your financial responsibility required to the Grand Rapids Home for Veterans for your cost of care, Supplementary Services, and Member Rights and Responsibilities. (The Member Income and Assessment Office will be able to estimate the projected monthly room and board assessment.)

If you would like a copy of this contract prior to admission, please call us.

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☐ Veteran ☐ Dependent ☐ New ☐ Readmission Date _____ Time _____

REQUIREMENTS FOR ADMISSION TO THE GRAND RAPIDS HOME FOR VETERANS

APPLICATION FOR ADMISSION

All members of the Armed Forces of the United States who have been honorably discharged and served not less than 90 days during a designated wartime period: 1st World War - April 6, 1917, to November 11, 1918 (to April 1920 if served in Russia); 2nd World War - December 7, 1941, to December 31, 1946; Cold War, Korean Conflict, Vietnam War or Persian Gulf War - beginning December 31, 1946, to present may apply for admission to said facilities. Veterans must be considered unemployable. Former members of the Armed Forces, otherwise qualified, who served less than 90 days and who were honorably discharged from service and who, as the result of service, acquired a service-connected disability or disease, may be admitted. All veterans must be residents of Michigan at the time of admission, unless an accredited Michigan veteran. Subject to available space and certain other requirements, a spouse, surviving spouse, former spouse or parent of eligible veterans may also be eligible for admission.

ALL QUESTIONS MUST BE ANSWERED. All questions on this form, including the medical certificate, must be completed OR THE APPLICATION WILL BE RETURNED. If the question does not apply, write "none" in the blank. Qualified war service must be verified by an acceptable discharge document. Where the discharge document has been lost, a transcript of service may be obtained by writing to the Adjutant General of the state in which such applicant enlisted.

THIS LINE IS FOR OFFICE USE ONLY	MEMBER NUMBER	LEVEL OF CARE (1 DOM, 2 NURSING, 3 SPECIAL-ALZHEIMER'S, 4 SPECIAL NEEDS M-1)	PRESENT LOCATION: BLDG	FLOOR	AREA	ROOM NO.	BED	ADMISSION DATE: MONTH	DAY	YEAR

PERSONAL INFORMATION

Application should be made out in ink or typewritten and notarized. Please print.

V.A. CLAIM NO.	SERVICE SERIAL NO.	SOCIAL SECURITY NO.	MEDICARE NO.

NAME OF APPLICANT - (Last, First, Middle)	SEX	BIRTH DATE (MONTH DAY YEAR)	BIRTHPLACE (CITY, STATE)

PERMANENT ADDRESS (Street & Number)	CITY	COUNTY	STATE	ZIP	PHONE ( )

TEMPORARY ADDRESS (Street & Number)	CITY	COUNTY	STATE	ZIP	PHONE ( )

HAVE YOU EVER BEEN A MEMBER AT THIS FACILITY? ☐ **YES** ☐ **NO** **IF YES, ENTER DATE** _____

REFERRAL SOURCE ☐ **Self** ☐ **Family** ☐ **Hospital*** ☐ **Nursing Home***

***NAME OF FACILITY**_____ **PHONE NO.**_____

***PERSON REFERRING**_____ **TITLE**_____

PERSONAL DATA (continued)

MARITAL STATUS (please circle): Single Married Never Married Widowed Divorced Separated

Race/Ethnicity (please circle): White, not of Hispanic Origin American Indian/Alaskan Native Asian Pacific Islander
Black, not of Hispanic Origin Hispanic

IF MARRIED OR WIDOWED, PLEASE COMPLETE THE FOLLOWING:

Spouse's Name (maiden)	Date of Marriage	Date of Birth	Date of Death

IF MARRIED AND EITHER APPLICANT OR SPOUSE HAD PRIOR MARRIAGE(S), PLEASE COMPLETE (ATTACH EXTRA PAGE IF NEEDED):

Death or Divorce?	Name of Person(s)	Date & County	Death or Divorce?	Name of Person(s)	Date & County
Death or Divorce?	Name of Person(s)	Date & County	Death or Divorce?	Name of Person(s)	Date & County

FATHER'S NAME	MOTHER'S MAIDEN NAME
☐ LIVING ☐ DECEASED	☐ LIVING ☐ DECEASED

NUMBER OF LIVING CHILDREN _____ **(PLEASE LIST)**

NAME	AGE	STREET & NUMBER	CITY	STATE	ZIP	PHONE
						( )
						( )
						( )
						( )
						( )
						( )

NOTIFY IN CASE OF EMERGENCY

PRIMARY	RELATIONSHIP	HOME PHONE	BUSINESS PHONE
		( )	( )

ADDRESS (Street & Number)	CITY	STATE	ZIP

SECONDARY	RELATIONSHIP	HOME PHONE	BUSINESS PHONE
		( )	( )

ADDRESS (Street & Number)	CITY	STATE	ZIP

FUNERAL ARRANGEMENTS

RELIGIOUS PREFERENCE (circle one): PROTESTANT CATHOLIC JEWISH OTHER: _____

FUNERAL HOME: **Are prepaid arrangements made? ☐ Yes ☐ No**

CEMETERY PREFERENCE: **Are prepaid arrangements made? ☐ Yes ☐ No**

COUNTY:

SERVICE INFORMATION

WARS SERVED IN (CHECK)	DISCHARGE TYPE FROM WAR SERVICE (CHECK)	BRANCH OF SERVICE	OUTFIT	IF DEPENDENT OF A VETERAN, CHECK ONE
☐ WW1 ☐ COLD WAR ☐ WW2 ☐ VIETNAM ☐ KOREAN ☐ OTHER ☐ PERSIAN GULF WAR	☐ 1 HONORABLE ☐ 2 MEDICAL ☐ 3 RETIREMENT	☐ AIR FORCE ☐ ARMY ☐ COAST GUARD ☐ MARINES ☐ NAVY		☐ MOTHER ☐ FATHER ☐ WIDOWED ☐ SPOUSE ☐ FORMER SPOUSE

NOTE: A military discharge document of the eligible veteran is required. Dependents must also provide proof of relationship to the eligible veteran. A marriage certificate or birth certificate, whichever is appropriate, is required (spouse or widow of veteran ☞ marriage certificate; parent of veteran ☞ birth certificate of veteran). Guardianship and/or conservatorship papers MUST BE PROVIDED as well, when applicable. All applicants may be required to provide true copies of marriage certificates, divorce decrees, and birth certificates. These must be made available at the time of admission.

ENLISTMENT DATE	PLACE OF ENLISTMENT	RESIDENCE AT TIME OF ENLISTMENT
SEPARATION DATE	PLACE OF DISCHARGE	
VETERANS ORGANIZATION HOLDING POWER OF ATTORNEY RE: V.A. RECORDS		

INSURANCE INFORMATION

MEDICARE COVERAGE **PART A HOSPITAL** ☐ **YES** **PART B MEDICAL** ☐ **YES**

EFFECTIVE DATE _____ **EFFECTIVE DATE** _____

OTHER MEDICAL INSURANCE ☐ YES ☐ NO	NAME OF COMPANY NAME OF INSURANCE CARRIER ADDRESS
PRESCRIPTION COVERAGE ☐ YES ☐ NO	NAME OF COMPANY NAME OF INSURANCE CARRIER ADDRESS
DENTAL COVERAGE ☐ YES ☐ NO	NAME OF COMPANY NAME OF INSURANCE CARRIER ADDRESS

VISION COVERAGE ☐ YES ☐ NO	NAME OF COMPANY NAME OF INSURANCE CARRIER ADDRESS

APPLICANT'S FINANCIAL DATA

This financial statement must be completed and signed by applicant, spouse, guardian or responsible person.
All questions must be answered. If the answer is none, put none.

PERSON HAVING FINANCIAL RESPONSIBILITY IF OTHER THAN APPLICANT

NAME (Last, First, Middle)		Phone ( )	
ADDRESS (Street & Number)	CITY	STATE	ZIP

PLEASE CHECK APPROPRIATE BOX: **NOTE: You must provide documented proof for each box checked.**
☐ FINANCIALLY RESPONSIBLE ☐ LEGAL GUARDIAN ☐ CONSERVATOR ☐ DPOA ☐ POA ☐ PATIENT ADVOCATE

OCCUPATION OF APPLICANT	LAST DATE WORKED	
FORMER EMPLOYER	YEARS OF SERVICE	
FORMER EMPLOYER	YEARS OF SERVICE	
AUTOMOBILE(S) - YEAR AND MAKE	PARKED AT GRHV? ☐ YES ☐ NO	
MONTHLY INCOME	GROSS	NET
V.A. PENSION OR COMPENSATION	$	$
SOCIAL SECURITY	$	$
OTHER RETIREMENT INCOME (source: _____)	$	$
PLEASE LIST OTHER INCOME BELOW 1.	$	$
2.	$	$
3.	$	$
4.	$	$
5.	$	$
RENTAL PROPERTY INCOME	$	$
LAND CONTRACT INCOME	$	$
DIVIDENDS	$	$
INTEREST	$	$

NAME AND ADDRESS OF BANKS, SAVINGS & LOAN, CREDIT UNIONS	TYPE OF ACCOUNT Please list: SAVINGS; CERT. OF DEPOSIT (CD); CHECKING; IRA; OTHER	AMOUNT
1.		$
2.		$

3.		$
4.		$
5.		$

APPLICANT'S FINANCIAL DATA continued

NAME OF LIFE INSURANCE COMPANIES	BENEFICIARIES	AMOUNT
1.		$
2.		$

Are you or your dependents receiving, or will be receiving, nursing care insurance payments? ☐ Yes ☐ No

LOCATION OF REAL ESTATE Street	City	State	Zip	VALUE
1.				$
2.				$

OTHER INVESTMENTS - IDENTIFY	VALUE
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$
8.	$

FINANCIAL STATEMENT FOR DEPENDENTS

FOR VETERANS OR APPLICANTS WITH DEPENDENTS ONLY

Applicants WITHOUT dependents, go on to page 9

This financial statement must be completed and signed by applicant, spouse, or conservator.

All questions must be answered. If the answer is none, put none.

SPOUSE: _____ (NAME) DATE LAST WORKED _____	SOCIAL SECURITY NUMBER

INCOME SPOUSE AND/OR MINOR CHILDREN	MONTHLY INCOME GROSS	MONTHLY INCOME NET
WAGES (source: _____)	$	$
SOCIAL SECURITY	$	$
OTHER RETIREMENT INCOME (indicate source below)		
1.	$	$
2.	$	$
3.	$	$
4.	$	$
RENTAL PROPERTY INCOME	$	$
LAND CONTRACT INCOME	$	$
DIVIDENDS	$	$
INTEREST	$	$
OTHER INCOME (indicate source below)		
1.	$	$
2.	$	$
3.	$	$
4.	$	$

NAME AND ADDRESS OF BANKS, SAVINGS AND LOAN, OR CREDIT UNIONS	TYPE OF ACCOUNT - Please list: SAVINGS; CERT. OF DEPOSIT (CD); CHECKING; IRA; OTHER	AMOUNT
1.		$
2.		$
3.		$
4.		$
5.		$
6.		$

AUTOMOBILE(S) - YEAR AND MAKE

continued...

NAME OF LIFE INSURANCE COMPANIES	BENEFICIARIES	AMOUNT
1.		$
2.		$

LOCATION OF REAL ESTATE STREET	CITY	STATE	ZIP	VALUE
1.				$
2.				$

OTHER INVESTMENT - IDENTIFY	VALUE
1.	$
2.	$

LIVING EXPENSES AND INDEBTEDNESS MONTHLY EXPENSES	MONTHLY AMOUNT
FOOD AND CLOTHING	$
TELEPHONE	$
ELECTRICITY	$
WATER & SEWAGE	$
HEAT	$
TAXES	$
HOME INSURANCE	$
HEALTH INSURANCE (OTHER THAN MEDICARE)	$
LIFE INSURANCE	$
CAR PAYMENTS	$
CAR EXPENSE	$
RENT - MORTGAGE PAYMENT	$
OTHER EXPENSES AND DEBTS (indicate source below)	AMOUNT
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$

continued...

DEPENDENT CHILDREN

DEPENDENT CHILDREN INCLUDE THOSE UNDER 18 YEARS OF AGE AND THOSE WHO, BECAUSE OF A DISABILITY, ARE STILL CONSIDERED DEPENDENTS

NAME	SOCIAL SECURITY NUMBER	AGE	SOURCE OF INCOME (IF ANY)	AMOUNT
1.				$
2.				$
3.				$
4.				$

MEDICAL EXPENSES

LIST ALL MEDICAL EXPENSES (indicate source below)	AMOUNT	REIMBURSEMENT EXPECTED	MEDICAL COSTS NOT REIMBURSED FOR
1.	$	$	$
2.	$	$	$
3.	$	$	$
4.	$	$	$
5.	$	$	$

I AGREE TO NOTIFY THE GRAND RAPIDS HOME FOR VETERANS OF INCREASES AND DECREASES OF INCOME, ASSETS AND EXPENSES PRIOR TO THE ADMISSION OF THIS INDIVIDUAL, AND AFTER HIS/HER ADMISSION TO THE GRAND RAPIDS HOME FOR VETERANS.

SIGNED BY: (PLEASE CHECK ONE) ☐ SPOUSE ☐ GUARDIAN ☐ OTHER RESPONSIBLE PERSON

NAME (PRINTED) _____

_____ _____

SIGNATURE DATE

continued...

MEDICAL INFORMATION

PHYSICIAN'S CERTIFICATE

THE PHYSICIAN'S CERTIFICATE MUST BE FILLED OUT AND SIGNED
BY THE APPLICANT'S PHYSICIAN PRIOR TO THE RETURNING OF THIS APPLICATION.

CURRENT DIAGNOSES (if psychiatric, please attach recent assessment, progress notes, etc.)

HEIGHT _____ WEIGHT _____ _____ current normal	BED SORES ☐ NO ☐ YES IF YES, WHERE? _____ _____ _____	KNOWN ALLERGIES (list)

PHYSICIAN'S ORDERS & CURRENT MEDICATIONS. LIST METHOD & FREQUENCY OF ACTUAL ADMINISTRATIONS. IF DIAGNOSIS DOES NOT JUSTIFY MEDICATIONS ORDERED, PLEASE EXPLAIN.

MEDICATION	FREQUENCY	DIAGNOSIS/REASON

DIET: ☐ Regular ☐ Diabetic ☐ Other

UNSTABLE MEDICAL CONDITIONS:	

continued...

REVIEW OF SYSTEMS

	NORMAL	ABNORMAL	COMMENT
EENT	☐	☐	
CARDIOVASCULAR	☐	☐	
PULMONARY	☐	☐	
GASTROINTESTINAL	☐	☐	
GENITOURINARY	☐	☐	
ENDOCRINE	☐	☐	
CENTRAL NERVOUS SYSTEM	☐	☐	
SKELETAL	☐	☐	

B.P.	TEMP.	PULSE	RESP.

	NORMAL	ABNORMAL	COMMENT
DERMAL/EENT	☐	☐	
HEART	☐	☐	
LUNGS	☐	☐	
ABDOMEN	☐	☐	
GENITOURINARY/PELVIC	☐	☐	
NEUROLOGIC	☐	☐	
MUSCULOSKELETAL	☐	☐	

ALL APPLICANTS MUST SUPPLY THE RESULTS OF A CHEST X-RAY TAKEN WITHIN 30 DAYS PRIOR TO ADMISSION AND A HISTORY AND PHYSICAL COMPLETED WITHIN THE LAST 90 DAYS.

EXAMINING PHYSICIAN

SIGNATURE	DATE	PHONE ( )
NAME (PRINTED)		
ADDRESS	CITY	ZIP

APPLICANT'S MEDICAL INFORMATION

Please √ appropriate box

SELF-CARE STATUS		INDEPENDENT	NEEDS ASSISTANCE	UNABLE TO DO
PERSONAL HYGIENE	BATHING	☐	☐	☐
	SHAVING	☐	☐	☐
	ORAL HYGIENE	☐	☐	☐
DRESSING	UPPER EXTREMITIES	☐	☐	☐
	TRUNK	☐	☐	☐
	LOWER EXTREMITIES	☐	☐	☐
FEEDING		☐	☐	☐
MOBILITY	SITTING	☐	☐	☐
	STANDING	☐	☐	☐
	TRANSFERRING	☐	☐	☐
	WHEELCHAIR	☐	☐	☐
	WALKING	☐	☐	☐
	STAIRS	☐	☐	☐

COMMUNICATION ABILITY	CAN SPEAK	☐ YES	☐ NO	English ☐ YES	☐ NO
	CAN WRITE	☐ YES	☐ NO		
	UNDERSTANDS SPEAKING	☐ YES	☐ NO	English ☐ YES	☐ NO
	UNDERSTANDS GESTURES	☐ YES	☐ NO		
	UNDERSTANDS WRITING	☐ YES	☐ NO		

BOWELS ☐ CONTINENT ☐ INCONTINENT

BLADDER ☐ CONTINENT ☐ INCONTINENT

SPECIAL NEEDS ☐ CATHETER ☐ COLOSTOMY ☐ TRACHEOSTOMY

APPLIANCES ☐ PROSTHESIS ☐ DENTURES ☐ GLASSES ☐ HEARING AID ☐ OTHER _____

BEHAVIOR/ORIENTATION

☐ FRIENDLY	☐ DISORIENTED	☐ ANXIOUS
☐ COOPERATIVE	☐ DEPRESSED	☐ FEARFUL
☐ QUIET	☐ DESPONDENT	☐ SUSPICIOUS
☐ ALERT	☐ DEMANDING	☐ WITHDRAWN
☐ CONFUSED	☐ ANGRY	☐ WANDERS
☐ NOISY		

☐ DELUSIONS	☐ INAPPROPRIATE
☐ HALLUCINATIONS	☐ SPECIAL PSYCHOSOCIAL NEEDS
☐ AGGRESSIVE	
☐ COMBATIVE	

ADDITIONAL COMMENTS REGARDING BEHAVIOR _____

_____

SIGNATURE OF PERSON COMPLETING FORM _____ **PHONE** _____

NAME (PRINTED) _____ **RELATIONSHIP** _____

Applicant's Medical Information, continued

Does the applicant have a PEG? ☐ YES ☐ NO If yes, size _____

Does the applicant have a G-tube? ☐ YES ☐ NO

Does the applicant have a Dobhoff? ☐ YES ☐ NO

Does the applicant have a trach? ☐ YES ☐ NO If yes, size _____

What type of feeding does the applicant receive? _____

Does the applicant have a shunt for dialysis? ☐ YES ☐ NO

Does the applicant have a prosthesis? ☐ YES ☐ NO If yes, type _____

Will the applicant have a Foley catheter? ☐ YES ☐ NO ☐ Suprapubic

If yes, for what reason? _____ Insertion date: _____

Does the applicant have an ostomy? ☐ YES ☐ NO If yes, what type of appliance? _____

Will the applicant require oxygen? ☐ YES ☐ NO If yes, what concentration? _____

Are restraints in use? ☐ YES ☐ NO If yes, what type? _____

Is the applicant combative? ☐ YES ☐ NO

If yes, describe: _____

Is there a history of active infectious disease? ☐ YES ☐ NO If yes, explain: _____

Is there a history of latex allergy? ☐ YES ☐ NO If yes, explain: _____

Has an influenza vaccine been given this year? ☐ YES ☐ NO

Has a pneumococcal vaccine been given? ☐ YES ☐ NO

Tuberculin test received? ☐ YES ☐ NO If yes, date and result: _____

History of actual/suspected infection/infectious disease:

Tuberculosis ☐ YES ☐ NO If yes, date: _____

Resistant Organism (any site) ☐ YES ☐ NO If yes, date: _____

Other _____ ☐ YES ☐ NO If yes, date: _____

Does the applicant have an open wound? ☐ YES ☐ NO

If yes, what type? ☐ Pressure Ulcer ☐ Surgical Wound ☐ Stasis Ulcer ☐ Other

Current Treatment Modality/Special Mattress: _____

While in acute care, did applicant receive any antibiotics? ☐ YES ☐ NO

If yes, please list name, dosage, date: _____

SIGNATURE OF PERSON COMPLETING FORM _____ **PHONE** _____

NAME (PRINTED) _____ **RELATIONSHIP** _____

Have you ever been arrested or convicted of a felony? ☐ YES ☐ NO

If yes, please list all arrests and/or convictions: _____

MICHIGAN FELONY STATUTE
FALSE PRETENSES

Michigan Compiled Laws Annotated Section 750.218 provides:

"Any person who shall by any false token or writing obtain from this State Institution care and services, the value of which exceeds $100 by intentional fraudulent misrepresentations or false signature before a notary shall be guilty of a felony punishable by imprisonment in the state prison for a period not to exceed ten (10) years ..."

It is unfortunate that a minority of veterans make false representations concerning their income and assets upon admission to this facility. This detracts from the services we are able to provide and increases the monthly costs to the honest veterans.

N O T I C E
AGREEMENT

For and in consideration of my admission to the Grand Rapids Home for Veterans, I hereby agree payment to the Board of Managers of the Grand Rapids Home for Veterans of any balance of money accumulated while a member of the Facilities, or due to me or on deposit with any bank, trust company, corporation or with any individual, at the time of my death; provided all such sums shall first be expended to pay for residual maintenance costs attributable to the deceased individual, and shall then be paid to the wife, minor children, or dependent mother or father in the order named.

If no such relative shall be found within a period of two years, or if no claim for the sums has been made within a period of two years, the balance of the money shall be paid into a fund in the hands of the Board of Managers of the Facilities to be expended by the Board of Managers to improve the service of the Facilities, pursuant to MCLA 36.61 as amended, P.A. 1905, No. 313.

I, _____, further depose and say that I will, if admitted to the Facilities, obey the rules and regulations prescribed for the Facilities, and obey all lawful orders of the officers of the Facilities, and agree to notify the Grand Rapids Home for Veterans of all changes in benefits or estate.

Please review your application and make absolutely certain that the information provided is accurate before placing your signature on this notarized document.

_____ _____

Signature of Applicant | Signature of Guardian (if applicable)

Name Printed _____ Name Printed _____

STATE OF MICHIGAN
COUNTY OF _____

On this _____ day of _____ A.D. 20____, before me, a Notary Public, in and for said county and state, appeared _____, to me personally identified, who, being first duly sworn, did depose and say that he had read the foregoing statements by him subscribed and that all questions answered and statements made by him are complete and factual and that he understands and is in agreement with the requirements for admission to the Grand Rapids Home for Veterans and hereby agrees to pay the balance of any funds accumulated while a member as provided by the above acts.

_____ _____

Notary Public | County, Michigan

My commission expires _____